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Translumbar Aortic Puncture and Retrograde Catheterization of the Aorta in Aortography and Renal Arteriography: Arteriography is accepted as a valuable adjunct to diagnosis in demonstration of cerebral and cardiac pathologic conditions. Although aortography has lagged a little behind these fields in general acceptance, it seems certain that it is a useful and safe addition to other diagnostic methods in special cases of renal disease and of vascular disease of the aorta and its branches.

The chief purpose of this paper is to describe a method of retrograde catheterization of the aorta through one of the branches of the femoral artery for the purpose of injecting radiopaque media at any level desired to outline the branches of the aorta. The authors' experiences in the past 2 years with needle puncture of the aorta and injection of radiopaque media have paralleled those reported by others. In general the technic of Dos Santos so well described by Nelson and by Wagner has been employed.

Technic. In figure 1 the site of needle injection for translumbar aortography is shown.

The patients have always been anesthetized, usually with pentothal but occasionally with spinal anesthesia. In children vinethene and ether have been used.

Needles larger in diameter than those recommended by others have been used. Two long (15 cm.) spinal needles, No. 16 and No. 17, were specially constructed for this purpose. The 6-inch length is essential in adults.

The x-ray examination is conducted on an ordinary radiographic table containing a Buckey grid and an overhead 200 MA tube, with the patient in prone position. An exposure time of 1/15 second is used to prevent blurring due to motion. Other factors include a 36-inch tube-film distance, a kilovoltage ranging from 80 to 95 and 13 MAS. Usually "Neo-iopax" is used as a contrast medium. Injections up to 3 times the usual dose for intravenous pyelography have been given in one afternoon. A "test dose" has been employed after a fashion, in that all the

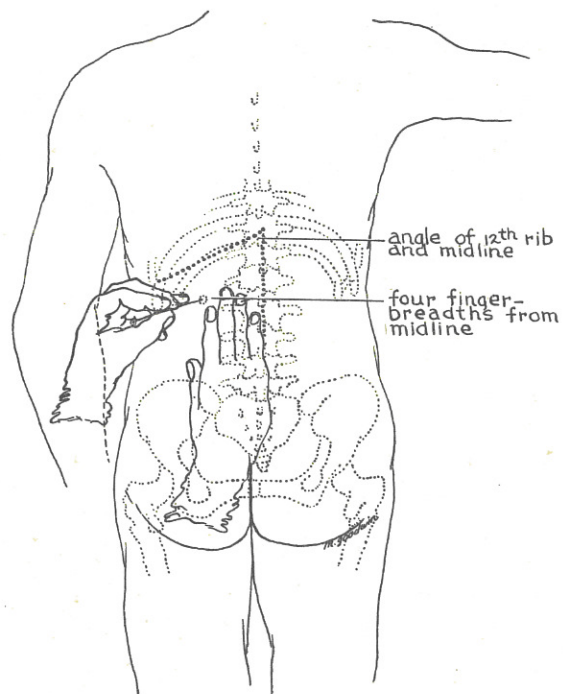


FIG. 1.—Site of needle injection for translumbar aortography. Patient is prone.



patients have had excretory urograms at least 24 hours prior to arteriography. A pressure pump has not been used. All injections have been by hand syringe.

Patients under spinal anesthesia have noted a brief wave of "heat" and a short period of dyspnea as the dye returns through the cardiorespiratory system. There is usually a slight transient blood pressure drop following injection. In 2 cases in which the dye extravasated during injection under spinal anesthesia, the patients complained of extreme pain for 5 to 10 minutes. This rapidly subsided, however, and a subsequent film showed complete absorption of the dye, without apparent lasting ill effects. In order to prevent extravasation of the dye due to inadvertent movement of the needle after a satisfactory aortic tap has been made, it is useful to place a supporting hemostat on the needle close to the skin. This prevents movement at the time of injection.

Retrograde Catheterization of the Aorta. A preliminary intravenous urogram is carried out on some day prior to the aortogram. On the day of the procedure the patient is prepared for anesthesia, and exposure of the femoral artery and its branches and insertion of the catheter is carried out in the operating room. Pentothal anesthesia has been used chiefly, although spinal anesthesia has been used occasionally. It could probably be done easily under local anesthesia, if desired. Figure 2 shows the anatomy and the site of incision. Either leg can be used. The dissection is not difficult, but it can be very tedious. The profunda femoris frequently lies high in the thigh, and its small circumflex branches run quite laterally and deeply. After the lateral circumflex branch of the profunda femoris is identified and dissected free, 2 traction sutures of medium silk are placed under it. The more distal one is ligated and held laterally. The proximal one is placed on sufficient tension to control bleeding, and a small nick is made with scissors in the artery between them. Then the ureteral catheter is introduced and passed upward 35 cm., which is the usual approximate distance to the renal arteries. It is important to use as large a catheter as possible in order to secure maximal concentration of the injected dye. A No. 10 F catheter is very satisfactory. Before the catheter is introduced, a large needle is placed in the proximal end and a three-way stopcock is fixed on the end of the

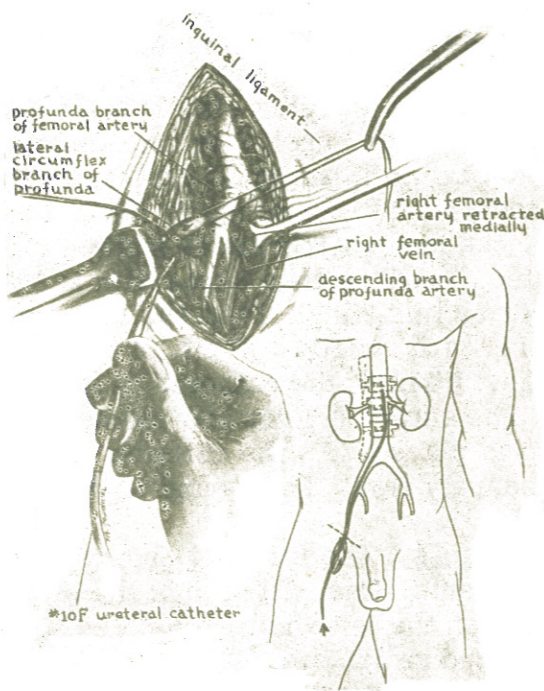


FIG. 2.—Method and site of retrograde catheterization of the branches of the femoral artery in the catheter method of aortography.



needle. The catheter is washed with saline to clear its lumen and to leave it full of a column of fluid, and the three-way stopcock is turned "off" so that the arterial blood will not flow into the catheter. It is sometimes very difficult, due to the angle of the vessels, to get the catheter started into the femoral artery. At this point, the assistant can often guide the tip of the catheter by pressure with his fingers outside the vessels. Once into the femoral artery, the catheter is easily passed upward to any height desired. It is then tied securely in place with the more proximal traction suture; and after suitable covering with sterile drapes, the patient is transferred to the x-ray rooms where the aortograms are made. It is very important to keep the catheter from being plugged with clots from the time it is introduced until the end of the procedure. To this end, an infusion of saline is attached to the three-way stopcock, and one of the team almost constantly injects small amounts of fluid. The arterial pressure is normally too high to allow for easy gravity flow. At first a mixture of saline and heparin was employed, but this is not necessary as long as the catheter is frequently irrigated. In the course of such a procedure a patient may receive as much as 1,500 cc. of saline in an hour or an hour and a half. The roentgen ray technics are the same as those described in the needle method. A scout film is first taken, and at this time a pilot injection of from 4 to 5 cc. of "Neo-iopax" is made. When the film is developed, the exact position of the catheter in relation to the renal or other desired arteries is determined; and the catheter is adjusted either up or down in order to get the optimum result with later films. Then 2 or more aortograms are made. In the first, 30 cc. of "Neo-iopax" is injected as rapidly as possible from a "Luer lock" syringe. The roentgen ray exposure is made at the end of injection. This film is seen before the last aortogram is made. If indicated, the catheter is still further adjusted. Next another scout film is made, as an excretory pyelogram is often present by this time. Then the last exposure is carried out at the end of rapid injection of from 10 to 12 cc. of the contrast medium from a small "Luer lock" syringe. Finally, the catheter is slowly removed after further infusion of saline. The suture holding the catheter in the artery is cut and another traction suture is placed. As the catheter is removed, the artery is held under tension and securely tied. The wound is then closed with interrupted black silk sutures.

Results. The femoral artery catheterization has been carried out 15 times in 14 patients. One patient had the procedure done twice, first on the right side and then on the left where the circulation, though not exactly the same, was comparable and satisfactory for the purpose. The results with the exceptions noted below under "Complications," were all very satisfactory.

In only 2 cases, however, was information gained that would not have been learned from the translumbar needle puncture method.

Complications. There have been no serious complications or reactions. However, there have been several troublesome mishaps, which may be attributable to the method but which are more likely related to the fact that it was a



new technic. In 1 case, early in the series, the procedure was attempted but was abandoned when the profunda femoris could not be identified. In another case, after satisfactory introduction of the catheter, it could not be passed beyond the iliac bifurcation, presumably due to arteriosclerosis. The catheter was not forced. The most serious complication occurred during an attempt to pass a catheter through the nearly obliterated femoral vessel of a one-legged man with thromboangitis obliterans. Obstruction was met in the region of the iliac vessels. Ill-advised force was used and subsequent films showed that the catheter had passed out of the artery into the perivesical region. After considerable thought and consultation, the catheter was removed and the patient was watched carefully. No apparent ill effect was noted. It probably would not have been possible to remove the catheter without mishap had not the artery been almost obliterated by the patient's disease. One patient developed a troublesome inguinal adenitis after the procedure, and in another there was a minor wound breakdown because of delayed healing. One or two patients have complained of a temporary numbness over the thigh when the lateral femoral cutaneous nerve was inadvertently traumatized. In 2 cases, moderately severe hemorrhage occurred at the time of catheterization because of difficulty in starting the insertion of the catheter. This was readily controlled with traction sutures, however, and the catheter was then passed relatively easily after an assistant helped to guide it through the sharp angle leading into the femoral artery. One patient complained of residual weakness of flexion of the right thigh, presumably due to interference of the blood supply to the right thigh muscles. None of this small series, or of the larger series of needle aortograms have suffered iodism or any recognized change in renal function. There have been no other recognized complications. The retrograde catheterization method has often been tedious and time consuming.

Aortography, both by the translumbar needle method and by the method of retrograde catheterization of the aorta has been a safe and often useful procedure, but it is not believed that it will ever become a routine diagnostic procedure, such as pyelography. However, there seems to be no good reason why it should not be used in all cases of imperfectly visualized kidneys and of renal masses of doubtful nature. It has unquestionably great use in vascular lesions involving the aorta and its branches.

The authors agree with Wesson in his evaluation of the procedure, "... (the) method well fulfills the four rules of perfect diagnosis; viz., (1) a guide to treatment, (2) answers the question of prognosis, (3) satisfies the curiosity of the doctor, and (4) is without hazard in his hands."

It is of interest to compare the translumbar needle method and the retrograde catheterization method. Both methods seem safe, and each gives satisfactory visualization of the renal and other vessels under optimum conditions. The chief advantage in the catheter method lies in the possibility of placing the dye injection at any level. The needle method is, however, much simpler and quicker after facility is gained in the technic of aortic tap, and the complications

are fewer, a factor which outweighs the advantage of the catheter method. At present, the authors believe that the needle method of aortography is the procedure of choice. If that fails or is unsatisfactory for any reason, the catheter method should be employed. The catheter method is also preferable in cases of aneurysms of the aorta or its branches. (Ann. Surg., November '50, W. E. Goodwin et al.)

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Prophylaxis and Treatment of Acute Respiratory Diseases with Antihistaminic Drugs: Four studies on the prophylaxis and treatment of acute respiratory diseases, particularly the common cold, with antihistaminic drugs were undertaken by the Naval Medical Research Unit No. 4 at the U. S. Naval Training Center, Great Lakes, Illinois. The study was divided into 4 series: (1) Prophylactic treatment in Navy male recruits; (2) Prophylactic treatment with therapeutic dosages in Navy male recruits; (3) Treatment of minor acute respiratory infections in Navy Wave recruits; (4) The prophylaxis and treatment of "colds" in volunteers.

Part I of the study was started in February 1950 and the purpose was to determine whether an antihistaminic drug can prevent the common cold and other acute respiratory diseases in a recruit population. All recipients of treatment were led to believe that each was receiving the antihistamine and that an untreated group would form the control series. Actually, a placebo was dispensed to one-half of those receiving treatment. In recruit populations minor acute respiratory infections, presumably caused by one or more viruses, are epidemic. In 352 male recruits an antihistamine was used in prophylactic dosage throughout their training period. A group comparable in size and stages of training was treated with placebos and a 3d similar group received no treatment, a total of 1103 being studied. A high incidence of acute respiratory diseases occurred during the study between February and April 1950, the majority of which were clinically classified as the common cold.

The results of the study showed no evidence that the antihistaminic drugs prevented these diseases or effected any important alteration in their symptomatology.

Part II of the study was conducted from 10 to 18 April 1950 following the influenza epidemic. Two antihistamine drugs, used in therapeutic doses, and a placebo were given to 357 male recruits formed into 3 groups. The influenza epidemic had subsided and no new cases were diagnosed during the period of study.

The results of the study showed that neither of the antihistaminic drugs demonstrated any ability to prevent the common cold which was epidemic at the time. The use of therapeutic doses before the onset of symptoms did not result



in the "aborting" of colds or make any important alteration in their symptomatology or duration.

Part III of the study was conducted in Wave recruits from 3 January to 11 April 1950. The antihistaminic drugs have been reported to be particularly effective in the therapy of the common cold within 1 to 24 hours after onset of symptoms. For the study 165 women patients (Waves) suffering from the common cold were admitted in groups receiving atropine sulfate, a placebo, and an antihistaminic drug.

The results from this study indicated that neither atropine nor the antihistamine aborted colds or effected any important variations in their symptomatology or duration.

Part IV. In connection with the studies done in male and Wave recruits it was then desired to include a study in a population which had extensive contacts in the surrounding community and in which the "colds" would be representative of those prevalent in civil populations. A volunteer group consisting of officers, senior petty officers, and their dependents was used in the study. This study was conducted from 3 January to 16 April 1950 and the same methods followed.

The results of the study in this group indicated: (1) Too few reported adequate usage of the drugs in the prophylactic schedule to allow critical evaluation of the results; (2) Those reporting the therapeutic usage had equally beneficial results from placebos and antihistaminic drugs, presumably due to psychological effects. (J. Lab. & Clin. Med., October '50, NAMRU No. 4)

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A Study of the Occurrence of Normal Rh-Negative Infants Born to Sensitized Rh-Negative Women: In studying the occurrence of Rh sensitization in Rh-negative women, 30 instances were found in which normal Rh-negative infants were born to mothers whose sera contained Rh antibodies ante partum. The sample was analyzed according to type and amounts of Rh antibodies present in the maternal serum ante partum, the trend of the antibody titer, the ABO blood groups of both mother and child, and the frequency of ABO compatibility between mother and child. The purpose of this study was to determine whether the birth of an Rh-negative baby could be predicted ante partum in a sensitized Rh-negative woman, and whether the women in the sample under consideration might exhibit any specific characteristic in common.

In this study, small amounts of Rh antibodies (2+ or less) occurring inconsistently in ante-partum tests were regarded as nonspecific and of no significance. The tests for Rh sensitization showed appreciable amounts of Rh antibodies to be consistently present in the sera of 17 Rh-negative women who subsequently bore

Rh-negative infants. In 7 instances the ante-partum antibody titer increased in intensity and in 10 instances the antibody titer remained constant. All women in whom the antibody titers were consistently present showed evidences of a high degree of Rh immunization in terms of the amount and type of antibody present, and in some instances by having previously borne an erythroblastotic infant.

In the other 13 cases, Rh antibodies were present on some occasions and absent on others. Only small amounts of Rh antibodies were present and considered to be nonspecific. They may be accounted for by variations in technic, unknown contaminations of serum or glassware, and possibly other factors. The authors also observed similar inconsistent antibody findings in a group of Rh-negative women who subsequently bore clinically normal Rh-positive infants.

It was found that the only basis for the prediction of an Rh-negative infant to be borne of a sensitized Rh-negative woman is first, the determination of the Hr status of the husband, and second, the trend of the maternal ante partum Rh antibody titer. If the husband is heterozygous (Rhrh) and the titer remains constant, the baby will likely be Rh negative; however, some highly immunized Rh-negative women may actually demonstrate a rising Rh antibody titer and still bear an Rh-negative infant. (J. Pediat., October '50, S. P. Lucia and M. L. Hunt)

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Obliteration of Pain at the Site of Reference by Intradermal Infiltration Anesthesia in First-Stage Labor: The author suggests a method of relief of pain, in the first stage of labor, based on interference with the vicerosensory reflex.

Anatomically, cutaneous branches of the 11th and 12th thoracic nerves supply the skin of the lower hypogastric area of the abdomen near the midline. The lateral cutaneous branch arising from the 12th nerve reaches the skin a short distance above the iliac crest, sending a filament medialward along the iliac crest and then passes downward to the skin of the buttock. Both the iliohypogastric and ilioinguinal nerves communicate with the last thoracic nerve and supply the skin over the inguinal ligaments and the symphysis. The sacral nerves supply cutaneous branches over the sacrum and the sacroiliac joints. Close questioning of patients in first-stage labor revealed consistent reference of pain to the areas of the skin supplied by the nerves mentioned above.

Abdominal pain was abolished by the infiltration of the skin with an anesthetic agent, starting at the midline just above the symphysis and continuing the infiltration in a linear fashion intradermally, first to the left and then to the right above the inguinal ligaments, out to the anterior-superior iliac spines and then up the midline of the abdomen for a distance of 7.5 cm. and laterally on each side for 2.5 cm. When the patient complained of associated back pain, the skin area over the upper sacrum and over the sacroiliac joints was infiltrated.



Most patients were treated with metycaine 1.5 percent solution to which epinephrine in 1:200,000 dilution was added. In most multiparas and in a good many primiparas a single injection sufficed during the first stage of labor. Approximately 30 cc. of solution was used for abdominal infiltration and up to 30 cc. for the back. The drug can be reinjected without any untoward effects. The infiltration can be started as soon as the patient is in labor and complaining of pain, regardless of the cervical dilatation because it will not stop the progress of labor. Any idiosyncrasy to the drug can be ruled out by the observation of a small intracutaneous wheal.

Forty cases were included in the series and were unselected. In all cases the anesthetic effectiveness of the drug was simultaneous with its administration without causing any alteration of the tone of the uterus or the frequency, intensity, or duration of the uterine contractions. Because of the cessation of pain, all patients became fully cooperative in the labor process. The only criterion used was the presence of painful contractions. Twenty-two patients had complete relief of pain, 15 patients had relief but backache was mentioned by the patients, 2 patients had fair relief, and 1 little relief. In this series there were 23 low-forceps deliveries, 4 mid-forceps deliveries, 2 Scanzoni maneuvers, 2 breech deliveries, and 9 normal deliveries.

The study indicates a simple method of relieving the character of pain in first-stage labor. There was strong suggestion that the actual labor in many patients was shorter than usual. The author emphasizes the spontaneity with which the infants cried and the pinkness of their color immediately upon birth.

It seems that patients with cardio-vascular-renal disease, impaired liver function, and blood dyscrasias could be relieved of pain by such a method free of systemic effects. In cases of prematurity or of sensitized babies of Rh-mothers such an anesthesia free of toxicity and depression upon the babies becomes highly desirable. (New England J. Med., 26 October '50, A. A. Abrams)

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Cancer Detected in Surveys: Like tuberculosis, cancer of the lung has the power to kill, develops insidiously, and produces shadows on the chest roentgenograms which may be detected in surveys in advance of symptoms. The roentgenographic shadows produced during the silent phases of both diseases show great similarity. But the two diseases differ in that the frequency of cancer of the lung is showing an alarming increase, whereas that of tuberculosis is declining. Moreover, cancer is invariably fatal unless treated by excision in its localized form.

It is not uncommon in chest surgical centers to find cancer upon surgical exploration in asymptomatic individuals. Such silent, asymptomatic cancers of

the lung not only exist, but are detectable. In accumulating data on ill cancer patients, it is at times possible to obtain for comparison roentgenograms taken previously at some period antedating symptoms. Some of these x-ray plates have shown an abnormal shadow corresponding in location to one produced by the known cancer. It is reasonable to assume that the shadows in the early and late films represented photographic records of the same growth process.

It is not at all surprising that tumors in their early developmental stage cast shadows on the roentgenogram. The majority of them originate in the larger bronchi, occlude the lumen, and cause segmental or subsegmental atelectasis. The obstructing growth need be but a few millimeters in size to produce secondary changes in the peripheral portion of the corresponding segment. These changes magnify the area of altered density many times, thus greatly increasing the likelihood of detection in survey work. Whether or not the shadow of a small, centrally placed tumor itself is obscured by shadows of normal structures at the lung root, the magnified secondary changes in the lung field fortunately serve to attract attention to possible fatal danger.

In the event that the cancer has originated in a small bronchus or in a bronchiole, its situation will then be peripheral and in the part of the lung field of greatest contrast. The direct shadows of the tumor will be seen. According to Rigler, shadows of growth as small as 3 mm. in diameter are detectable.

Difficulties experienced by doctors in the past in differentiating lung cancer from other conditions may be illustrated by citing experiences in the author's clinic. In the past 12 years, 849 patients suffering from primary carcinoma of the lung have been studied. Of this number, 824 had symptoms when observed and had been under medical supervision for approximately 6 months on the average. This delay in detection resulted from trials of treatment for conditions incorrectly diagnosed. The most common erroneous diagnosis was tuberculosis. If abnormal shadows happened to be in the upper half of the lung field, the previous diagnosis was usually tuberculosis. If the shadow was in the lower lung field, the most likely diagnosis was bronchitis, bronchiectasis, or atypical or virus pneumonia.

According to Bloomquist, in 10 city-wide surveys sponsored by the Public Health Service, 1,382 possible tumors were found in 1,780,178 persons examined. The yield was 0.8 per 1,000. The final breakdown of this group of tumor suspects is not available as yet. However, in Minneapolis, Seattle, and Washington, the yield of primary pulmonary malignancy of all types (not including metastatic disease) was about 0.1 per 1,000 according to Hilbish.

There is reason to doubt seriously that the yield of primary cancer is as low as these reports indicate because of several factors. There are possibilities of error in identifying shadows; some cases thought to be tuberculosis turn out to be cancer. Moreover, there is a time lag in the follow-up. Unless suspect cases



are studied promptly, the true value in saving of lives will be lost. Metastatic malignancy will modify the statistics. Some persons in whom verification has not been obtained clinically or at autopsy will die of cancer, and these cases will not be included in the statistics. Finally, patients with both cancer and tuberculosis are likely to be included only in the tuberculosis statistics. Some patients with an old tuberculous focus in the lungs may have this focus broken down by a malignant process, thus liberating tubercle bacilli in secretions from the lung.

Since the value of screening for asymptomatic tuberculosis is established and these programs are being undertaken, there is a real opportunity to find cancer in its silent stage as a by-product of these surveys. Furthermore, it is impossible to divorce consideration of the two diseases since evidence obtained by roentgenographic examination in early tuberculosis and cancer is often indistinguishable. Suspects in both categories require further investigation. The only difference is the urgency of the study. It is suggested that, whenever chest roentgenographic programs are in progress, the follow-up of cases be geared to meet the necessity of identifying the two diseases accurately and promptly. This might be done as follows:

1. Invite agencies interested in cancer detection to cooperate and take over that phase of the follow-up.
2. Acquaint all physicians who read the survey films and all those who are to advise patients that it is difficult or impossible to differentiate the shadows of silent tuberculosis and silent cancer.
3. Accelerate the follow-up program in order to save valuable time in the event the survey film has revealed an early cancer.

The author emphasizes that all persons suspected of having cancer must be differentiated promptly, for delays in diagnosis spell disaster. Of all sites for internal cancer, the lung should be the most favorable from the standpoint of early detection for these reasons:

1. Mass screening for tuberculosis automatically screens for cancer.
2. Multiple tests are available to aid in differentiation between tuberculosis and cancer.
3. Surgical exploration and removal are safe and effective when promptly applied in silent cancer. (Am. Rev. Tuberc., November '50, R. H. Overholt)

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Duodenal Fistula: The authors reviewed 18 cases of duodenal fistula reported since 1937 and have added 6 additional cases bringing the total to 24 to be used in discussing their subject.

Duodenal fistula is most commonly encountered as a complication following right upper quadrant abdominal surgery. This was true in 23 of the 24 cases here reviewed. The mechanisms by which the fistula is produced at or following operation are varied and may be multiple. Among them are: accidental trauma to the duodenum during biliary surgery, right hemicolectomy, nephrectomy; failure to obtain and maintain a satisfactory closure of a perforation of the duodenum due to ulcer or other nonoperative trauma (5, or possibly 6, cases); and leakage from the duodenal stump following gastric resection (9 cases, the most common single cause). Infection, impairment of blood supply, hematoma formation, poor nutrition, and improperly placed drains all may contribute to the development of a duodenal fistula.

There are 2 types of duodenal fistulas: the "lateral" type which occurs with the bowel in continuity and the "end" type in the duodenal stump which usually follows gastric resection. The "end" type fistula is less common, and at the same time less serious, than the "lateral" type, for morbidity and mortality. In a series reported by Bartlett and Lowell only 14 of the 128 cases were of the "end" type. In this series, 9 of the 24 cases were of the "end" type. Undoubtedly, this increase in incidence of the "end" type fistula in later years is a reflection of the acceptance of radical gastric resection over lesser surgical procedures in the treatment of complicated duodenal ulcer.

The recognition of duodenal fistulas complicating surgical procedures on or about the duodenum is usually not difficult. If drainage was established primarily, the first sign of a fistula may be the appearance of watery, bile-stained fluid on the dressings, often in copious amounts. In undrained cases onset is heralded by epigastric or right upper quadrant pain. The wound may become inflamed and indurated, and open spontaneously to discharge duodenal content. On the other hand, a deep intra-abdominal collection may form and require surgical drainage to reveal the true nature of the complication. Rarely is the picture that of spreading peritonitis.

When dye such as carmine or methylene blue is given by mouth, there is prompt appearance of the dye from the "lateral" type fistula. Gastro-intestinal barium studies may yield additional information concerning size and location of the fistula.

At the occurrence of a duodenal fistula, the care of the patient is complicated immeasurably. An excessive loss of fluid and electrolytes must be replaced. Adequate nutrition must be maintained. Every effort should be made to prevent or minimize the excoriation of the skin produced by the irritating secretions discharged from the fistula. Finally, operative closure of the fistula may be necessary if spontaneous closure does not result after a reasonable length of time.



Prompt therapy cannot be too strongly emphasized. As much as 4,000 cc. of fluid may be lost through a duodenal fistula daily, and delay in restoring fluid and electrolyte balance may result in biochemical changes which are irreversible. Factors influencing the composition and amount of drainage are type of fistula, "end" or "lateral"; intake, both enteral and parenteral; location and size of the fistula; and the intraduodenal pressure.

In the "lateral" type fistula at or below the ampulla of Vater, there is loss of secretions of the stomach, duodenum, liver, and pancreas. In "lateral" type fistulas located near the pylorus, there will be a relatively greater loss of stomach contents than pancreatic and liver secretions. The opposite occurs in "end" type fistulas with loss of pancreatic secretion and bile and little or no loss of the gastric juice. The treatment of each patient, therefore, must be individualized on the basis of the above considerations.

When feasible, the enteral route should be utilized to its fullest extent for fluid and electrolyte replacement and for maintenance of nutrition. In the presence of "end" type fistulas complicating gastric resection and associated with a functioning gastro-enterostomy, little recourse to parenteral therapy may be necessary. A well-balanced diet complete in mineral and accessory food factors may be given by mouth. However, the possibility of improper digestion and deficient absorption due to loss of bile and pancreatic juice from the fistula must be considered. Occasionally, it is possible to collect and re-feed these secretions.

In dealing with "lateral" type fistulas, on the other hand, enteral feeding may not be feasible or beneficial and actually may be harmful. A goodly portion of the fluid and food taken by mouth may be lost through the fistula. In addition, the flow of gastric, biliary and pancreatic secretions through the fistula may be increased so markedly by mouth feeding that the net result, from the standpoint of intake-output ratio, is a loss rather than a gain. When a Miller-Abbott tube can be successfully passed beyond a "lateral" type duodenal fistula and into the upper jejunum beneficial feeding may be accomplished through the tube. The passage of a feeding tube through the fistulous opening and into the distal bowel has been accomplished. However, this method of enteral feeding is undesirable because it retards or prevents spontaneous closure of the fistula.

The ~~parenteral~~ routes may be used to supplement enteral feeding. In some instances the problems of fluid and electrolyte replacement and maintenance of nutrition must be solved entirely by administration of parenteral fluids. Glucose in water, saline solution, plasma, serum albumin, protein hydrolysates, and whole blood are used as indicated. Therapy in terms of type and amount of solution administered is controlled by accurate intake and output records, including estimation of loss through the fistula, daily weight charts, frequent blood chemistry estimations, and above all, evaluation of clinical response. Maintenance of an adequate daily-urinary output, 1,000 to 1,500 cc., is the best clinical guide with

respect to fluid requirements. Overloading the patient with saline solution is to be avoided. The necessity for potassium replacement, particularly during long periods of parenteral feeding, is to be considered.

Very occasionally, it is necessary to resort to operative methods for solving the feeding problem. Jejunostomy is the simplest of the procedures available and may be life saving in selected cases. Gastro-enterostomy with pyloric exclusion has been recommended to convert a "lateral" into an "end" type fistula and permit effectual mouth feeding.

Finally, surgical closure of the fistula must be considered when after prolonged nonoperative treatment, spontaneous closure does not occur. In the 24 cases being discussed, only 5 were treated surgically. Three had jejunostomies for feeding purposes. In 2 of these, the fistula healed spontaneously, and 1 patient died. Two cases required surgical closure of the fistula. (Ann. Surg., November '50, CDR R. B. Brown, MC, USN; CDR R. C. Speir, MC, USN; and LT J. W. Trenton, MC, USN)

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Preliminary Note on Transorbital Lobotomy--A Warning: A preliminary report on some recent experiences with transorbital lobotomy is being made with the hope that caution may be used in carrying out this procedure. This is contrary to the verbal reports from the United States and France to the effect that this operation carries little risk, that it can be done using electroshock as an anesthetic and is therefore easily performed in doctors' offices.

Fiamberti, Freeman, and Moore advocate the procedure for the following reasons:

1. This procedure can be performed in a relatively short period of time, thus enabling a large number of patients to receive the benefit of this operation in any one centre.
2. The patients are ambulatory about the ward within 24 hours and this lessens nursing care barring complications.
3. The patients' stay on an active neurosurgical unit is only 5 days, barring complications.
4. The entrance of the transorbitome is into a relatively non-epileptogenic area of the frontal cortex, and few cases of postoperative focal seizures have been recorded to date.
5. The procedure does not introduce undesirable personality patterns, or aggravate existing ones. The intellectual level is not disturbed as by formerly tried methods.
6. If necessary, the patient can be reoperated upon after 12 months by a more extensive procedure.
7. The expense to the patients in civilian practice is not so great as in the other psychosurgical techniques.



8. It can be performed by adequately and competently trained personnel in proper surroundings, if available in various mental institutions.

The authors have performed a series of lobotomies for schizophrenia, using the standard Watts procedure (11), the McKenzie technic (11), and the transorbital method (5). There were no infections in 22 patients operated on by standard methods, but 1 case of infection occurred in the 5 transorbital lobotomies that were done. In spite of preoperative administration of prophylactic penicillin administered in doses of 300,000 units daily, the patient developed a periorbital cellulitis, with temperature of 101 to 102° F., beginning 6 hours postoperatively, continuing for 4 days. The upper eyelid was tense and swollen shut, and the inflammatory reaction spread peripherally to include the skin covering the right zygoma down to a line joining the right ear to the corner of the mouth. Intravenous fluids, hot compresses, aureomycin ophthalmic drops, 11 million units of penicillin, and 560 grains of sulfadiazine were required to combat the infection, which did not abate until the 8th postoperative day. Cultures of the pus showed a moderate growth of micrococci, evidence of anaerobic streptococci, and bacteroides.

Thus, transorbital leucotomy is not in all cases the innocuous procedure that it is reputed to be, even when done under the strictest aseptic technic in well-equipped operating theaters with competently trained staffs. It is felt that caution should be advised in the transorbital procedure. (Treatment Services Bull., October '50, H. Elliott and H. E. Beardmore)

\* \* \* \* \*

Insulin Resistance: A case of insulin-resistant diabetes associated with the autopsy observation of metastatic carcinoma of the pancreas and a critical review of the 50 cases of insulin resistance occurring in the literature form the basis of this report. Insulin resistance is a state which requires 200 or more units of the hormone per day for longer than 48 hours for regulation of a non-acidotic person. It may occur at any age and may last for a few days or several years. No fundamental relationship exists between resistance and allergy. There is no significant incidence of any associated disease or pathological process occurring in resistant patients. This indicates that the common practice in the literature of attributing resistance to various disease processes should be discontinued. The fact that it may occur in persons who do not have diabetes mellitus but are undergoing shock therapy suggests that an alteration of the carbohydrate cycle plays no role in its causation.

Insulin resistance should be differentiated from conditions causing fundamentally high requirements, as severe juvenile diabetes, and from disorders resulting in a temporary increase in insulin requirement: poor absorption from the injection site (insulin lipodystrophy, shock and congestive heart failure),

hyperthyroidism, pheochromocytoma, surgical procedures, trauma, acute infectious processes, pituitary basophilism, adrenocortical carcinoma, and diabetic acidosis.

The ultimate cause of insulin resistance is yet unknown, although it now seems reasonably certain that circulating insulin-neutralizing antibodies are the cause of a number of cases. Other possibilities to be clarified by future study are inactivation of insulin by antibodies fixed in the tissues, and the presence in excess in the body of a naturally occurring insulin antagonist, such as "insulinase," "glycogenolytic factor," or trypsin.

Management of insulin resistance is not difficult, since absolute refractoriness to the hormone probably does not occur and large doses nearly always have the desired effect of lowering the blood sugar. Therefore, these patients should be treated with amounts of insulin sufficient to control glycosuria, no matter how large that dose may be. They should be warned to watch for hypoglycemia, since sensitivity to the hormone may return abruptly. (Arch. Int. Med., November '50, J. K. Davidson and E. E. Eddleman)

\* \* \* \* \*

Evaluation of the Operative Indications and Results in the Fenestration Operation for Otosclerosis: In an investigation of the results obtained by the labyrinth fenestration operation for otosclerosis, the author made an analysis on the basis of the various factors commonly known to be important in determining the suitability of the patient for operation. A comparison of the results obtained in a group of patients from 15 to 25 years of age with a group from 45 to 60 years of age was thought to reveal certain features that have significance in the selection of patients for operation and in the prognosis.

The chief factors considered in the author's selection of patients were: (1) degree of deafness of the patient; (2) type of deafness present, as determined by air conduction audiometry, bone conduction audiometry, tuning fork tests, and caloric tests; (3) condition of the tympanic membranes; (4) condition of the eustachian tubes; (5) age of the patient; (6) amount and type of tinnitus; (7) temperament and psychology of the patient; (8) history of the development of the deafness; and (9) general condition of the patient.

Results obtained with the fenestration operation were analyzed from the standpoint of the degree of deafness before operation, the age of the patient, and the bone conduction before operation. Preoperative degree of deafness. Two groups of patients operated on were compared; one group was composed of 16 patients with a mild preoperative loss of hearing, averaging 38 or less decibels, and the other group was composed of 22 patients with a severe preoperative hearing loss averaging 62 or more decibels. The average improvement of hearing in the 16 mildly



deaf patients was 13.2 decibels and in the 22 severely deaf patients 20.3 decibels, indicating that the amount of improvement obtained in the mildly deaf patients is much less than the improvement obtained in the severely deaf patients.

Age of the Patient. One group of patients was composed of 48 patients from 14 to 26 years of age, and the other group of 32 patients 45 years of age or older. The average improvement in hearing in the 48 patients of the younger group was 16.7 decibels. This computation included 16 patients who were considered to have unsuccessful results (less than 15 decibels of improvement). The average improvement in the 32 successful cases was 23.5 decibels.

The average improvement in hearing in the 32 patients of the older group, including 9 patients with unsuccessful results, was 16.46 decibels. The average improvement in the 23 successful cases was 22.1 decibels.

It is significant that the hearing improvement after operation was practically the same in the 2 groups. It was observed that a higher percentage of success was obtained in the group older than 45 years of age than in the group younger than 25 years, but that a higher percentage of patients in the younger group obtained hearing to a practical and serviceable level.

Preoperative Bone Conduction, 2048 Frequency. This series consisted of 2 groups, the members of 1 group all having a preoperative bone conduction loss of 15 or less decibels at the 2048 frequency (essentially normal bone conduction), and the second group having a preoperative bone conduction loss of 30 or more decibels at the 2048 frequency. The average improvement at the 2048 frequency in the 45 patients with normal bone conduction (at the 2048 level) was 24.55 decibels. The average improvement at the 2048 frequency in the 43 patients who had a bone conduction loss (at the 2048 frequency) of 30 or more decibels was 21 decibels. It was thus observed that the improvement in hearing was almost as good in those cases with poor bone conduction (at 2048) as it was in those cases with normal preoperative bone conduction (at 2048), 21 as compared to 24.5 decibels.

It seemed probable that tinnitus near the pitch of the 2048 frequency masked the reception of the audiometric tone in some cases. Possibly, a combination of factors that are not well understood could influence the bone conduction at 2048 to give a reading that is not truly representative of the auditory nerve function at this level. A conclusion that might be drawn, therefore, is that a considerably reduced bone conduction at the 2048 frequency level does not necessarily indicate auditory nerve degeneration at that level and does not necessarily give a bad prognosis for results of the fenestration operation. (Arch. Otolaryng., October '50, E. H. Campbell)

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Uses of Pentobarbital Intravenously: A simple, successful method of complementing conduction anesthesia (topical, infiltration, regional, peridural, or spinal) by employing pentobarbital (nembutal) intravenously is presented. Packaged as a stable liquid, it is useful whenever instant hypnosis for control of nervousness or actual convulsions is needed by the physician in the home, office, or hospital.

Pentobarbital (nembutal) is ethyl (1-methyl-butyl) barbituric acid and belongs to the group of short- (not ultra short-) acting barbiturates. It is supplied by the manufacturer in 50 cc. bottles containing 50 mg. ( $3/4$  gr.) per cc., is stable in solution, and multiple doses can be safely drawn from this stoppered bottle. Ampules are also available containing powder in 0.5 Gm. ( $7-1/2$  gr.) dosage to be made up fresh with distilled water or saline. When administered intravenously its effects are seen almost instantly and may vary from drowsiness to complete anesthesia, depending on the total amount of the drug given and the individual reaction to it.

There is no average dose that can be relied upon to produce similar effects in different individuals. Pentobarbital must be given symptomatically, slowly (1 cc. per minute of 5 percent solution was found satisfactory); the maximal depression is reached from 10 to 15 minutes after the time of injection. Once in circulation it is beyond the reach of the anesthesiologist. If a conversation is maintained during this slow administration there is little danger of overdose and its accompanying respiratory depression. When the patient ceases to uphold his side of the conversation, an additional 1 cc. is given and the needle withdrawn from the vein.

Usually the patient will sleep from 30 to 60 minutes, depending on the effect of the premedication and providing there is no painful stimulation. After 10 to 20 minutes he can be aroused from this sleep by speaking in his ear slightly louder than normal. It should be remembered that the barbiturates are primarily hypnotics and do not possess analgesic properties except in anesthetic doses. Within the range of clinical use, the safety of pentobarbital intravenously is without question (if given slowly, 1 cc. per minute), for Abbott reported injection of 1.5 to 2.5 Gm. without mishap. He further stated that a dose of 30 to 40 percent of this will produce hypnosis and 60 to 70 percent of this dose (1.2 to 2.5 Gm.) will produce complete analgesia.

The authors have found pentobarbital to be useful in conjunction with local or regional anesthetics, particularly spinal anesthesia. Pentobarbital allays apprehensiveness, and averts the talkativeness frequently evinced by patients under the influence of preoperative sedation. It enables the patient receiving local anesthesia to be blissfully asleep rather than aware of his surroundings and the clatter and chatter of the operating room. It complements spinal anesthesia in cases in which undue traction is not expected. It does not enhance laryngeal reflexes and one can safely insert an airway or pass a Levine tube without fear



of laryngospasm. If it is necessary to inflict painful stimuli or heavy traction, these patients will thrash about on the operating table; for such conditions, light nitrous oxide oxygen offers an easy and excellent supplement.

In combination with the other drugs used for preoperative sedation such as morphine and scopolamine, pentobarbital enhances the amnesic effect. Like other barbiturates, pentobarbital also affords a degree of protection against untoward toxic reactions occasionally seen as a part of conduction anesthesia.

Pentobarbital intravenously has a safe clinical range. A more accurate individualized dose is given by the intravenous route than by the oral or rectal route and the effect is prompt and transient. It requires a minimum of apparatus and can be given in the patient's room with little fear of respiratory arrest or laryngospasm. Given preoperatively, it acts as a basal anesthetic and materially reduces the amount of other anesthetic agents required. In obstetric analgesia, when used with conduction anesthesia, the dose needed to allay restlessness does not appreciably retard the spontaneous respiration of the newborn infant. It is an excellent adjunct to spinal anesthesia without traction. It can be used for rapid hypnosis in the home, the amount being measured by using small doses. Repeated administration late in the operative procedure produces excessive postoperative restlessness.

If more sedation is needed than that provided by one intravenous dose of pentobarbital, barely sufficient to produce unconsciousness, then an ultra short-acting barbiturate such as pentothal repeated in small doses is preferable. It should be kept in mind when using intravenous pentobarbital in patients who are not to be hospitalized that the disorientation characteristic in those having had one of the barbiturates may appear briefly. It should not be used by a physician unwilling to take the time (1 cc. per minute) to give the drug slowly, for an overdose can easily be given with a rapid injection technic. It should not be used in patients with moist sounds (from any cause) in the lungs. High or low blood pressure is a contraindication to its use, as is impaired renal function. Inability to find a vein is indirectly a contraindication which almost automatically bars children and obese adults. (Postgrad. Med., October '50, H. M. Ausherman and O. B. Crawford)

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Hemolytic Anemia in Myelogenous Leukemia with Splenectomy: There have been many reports in recent years of splenectomy for hemolytic anemia, thrombocytopenia, or pancytopenia resulting from vascular, infectious, or neoplastic involvement of the spleen. Hemolytic anemia has been observed in a few patients with leukemic splenomegaly. The leukemia has usually been of the lymphocytic variety. The authors report a case which is an unusual instance of hemolytic anemia occurring in a patient with myelogenous leukemia in which splenectomy was of prolonged benefit.

Anemia is one of the major complications of leukemia. It is ordinarily due to leukemic replacement or alteration of the hematopoietic tissues. Occasionally it results from inadvertent damage to the bone marrow during therapy. Anemia resulting from accelerated red cell destruction is rare in leukemia, but its recognition may lead to worthwhile therapeutic measures.

In the authors' patient, accelerated red cell hemolysis was suggested by the presence of jaundice, reticulocytosis, and increased percentage of erythroid cells in the bone marrow. Quantitative studies of fecal urobilinogen excretion and red cell survival were not done but might be necessary in some cases for diagnosis. The paucity of erythroid elements in the splenic material indicated that this organ was not an important site of red cell production, which might have been regarded as a contraindication for splenectomy.

The pathogenesis of hemolytic anemia associated with neoplastic diseases, the relative importance of mechanical and humoral factors, and their relationship to the spleen has been uncertain. Autoantibodies have been demonstrated more frequently in recent years by improved methods in many patients with "symptomatic" hemolytic anemia. Tests for isoagglutinins and isohemolysins in saline and bovine albumin medium as well as the Coombs antiglobulin test were negative in the authors' patient, but were done only after splenectomy. The frequency with which autoantibodies have been demonstrated by these technics in symptomatic hemolytic anemia suggests, however, that autoimmunization may often be responsible for the accelerated red cell hemolysis.

Attempts to modify the hemolysis in symptomatic hemolytic anemia have included splenectomy and treatment of the underlying disease. Increased hemolysis has occurred in patients with widespread tumors in whom there was no obvious involvement of the spleen. The resection of localized tumors has led to the cessation of abnormal hemolysis in some instances, but in others splenectomy has been necessary. Local irradiation therapy has arrested hemolysis in Hodgkin's disease and general irradiation in leukemia. In other instances, splenectomy has been necessary and productive of temporary or prolonged benefit.

Hemolytic anemia associated with myelogenous leukemia is apparently very rare. One patient has been reported in whom splenectomy was followed by apparent cessation of hemolysis but death occurred in a few weeks from leukemia. The authors' patient has survived 30 months after splenectomy and is still in good health. The leukemia was unusually chronic and there was no clear indication that the splenectomy hastened or retarded its course. (Blood, October '50, U. Jonsson et al.)

\* \* \* \* \*

En Masse "Pelvic Viscerectomy" with Uretero-Intestinal Anastomosis:  
"Pelvic viscerectomy" is the natural outgrowth of two well founded operative pro-



cedures, cystectomy with uretero-intestinal anastomosis and abdominoperineal resection of the rectum and the lower sigmoid colon.

As used in this discussion, the term "pelvic viscerectomy" refers to the en masse removal of rectum, lower sigmoid colon, bladder and prostate in the male or en masse removal of the rectum, lower sigmoid colon, bladder, internal genitalia and vagina in the female. In both male and female patients, this procedure includes simultaneous en bloc excision of fatty areolar tissue and peritoneum surrounding these viscera and the regional hypogastric, external iliac, common iliac, and presacral lymph nodes.

There is a sizable group of patients with malignant changes limited to the pelvis that can be afforded a great deal of comfort and possibly "cure" if certain technical problems connected with the operation of pelvic viscerectomy can be overcome. Included in this group are patients with carcinoma of the rectum or sigmoid colon which has invaded bladder or ureters by direct extension and which shows no evidence of invasion beyond the pelvis. Other types of locally invasive malignant neoplasms, such as carcinoma of the cervix, are not included in this present study.

Pelvic viscerectomy presents three problems:

1. The operative procedure is severe.
2. The procedure for uretero-intestinal anastomosis is subjected to certain limitations in that the right ureter is usually transplanted to the cecum and the anastomosis is carried out as a one stage procedure.
3. Disposition of the lower alimentary canal must be made in such a way that it can care for both fecal and urinary excretion.

These technical problems were met in a series of 9 cases of extensively invading carcinoma of rectum and sigmoid colon. The operative mortality has not been prohibitive, and the early results of the operation are encouraging. Of course, it is too early to predict the curability rate of the operation as the first patient in the series was operated on September 23, 1947.

The authors discuss the anatomic, pathologic, and technical problems connected with pelvic viscerectomy for extensively invading rectal and sigmoid cancer. In a small series of 9 patients results indicate that this operative procedure is feasible, affords real palliation, and provides the possibility of "cure". Of the 9 patients 3 died shortly after operation, 3 survived 2 months, 4 months, and 7 months respectively. Three are living in good condition 14 to 29 months after operation and are leading essentially normal lives and have resumed their usual occupations. (Arch. Surg., November '50, E. S. Brintnall and R. H. Flocks)

\* \* \* \* \*

Racial Incidence of Blood Groups: The frequency of the blood groups in various races of the earth has been extensively studied by anthropologists. The distribution of the subgroups has not yet received the same exhaustive attention. In general, the frequency of the A agglutinin decreases as one progresses from Western European stock eastward to the Pacific Ocean, whereas the B agglutinin increases. The findings for many races have been tabulated by Weiner. It is convenient to remember that the approximate incidence in Caucasians in the U.S. is group O, 45 percent; group A, 40 percent; group B, 10 percent; and group AB, 5 percent. In contrast the proportions in the American Negro are: group O, 44.2 percent; group A, 30.3 percent; group B, 21.8 percent; and group AB, 3.7 percent. In the American Indian the incidence of the groups varies considerably. In the Blackfeet and Bloods the incidence is approximately: group O, 22.8 percent; group A, 76.7 percent; group B, 0.0 percent; and group AB, 1.0 percent. In the Navajos: group O, 69.1 percent; group A, 30.6 percent; group B, 0.2 percent; and group AB, 0.0 percent. The Chinese vary in different regions of their country but results are summarized as follows: group O, 30-45 percent; group B, 20-35 percent; group A, 22-38 percent; and group AB, 6-11 percent. There is a similar range in the Japanese. (Blood Transfusion, E. L. DeGowin, R. C. Hardin, and John B. Alsever, W. B. Saunders Co., 1949)

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Course in Anesthesiology: An intensive 4-months' course of instruction in anesthesiology will be conducted at the National Naval Medical Center in conjunction with the Georgetown University Hospital, beginning in January 1951.

Medical officers on active duty in the Navy or Naval Reserve are eligible to apply for the course. Those officers selected will attend on a temporary duty basis and may anticipate assignment to an anesthesia service upon completion of the course. Medical officers reporting for the course on temporary duty from West Coast activities will be assigned to permanent duty stations on the East Coast and not returned to the West Coast upon completion of the course.

Applications for the course should be forwarded to the Chief of the Bureau of Medicine and Surgery. Reserve medical officers should include an agreement to serve on active duty for a period of one year following completion of the course. A service agreement is not required for medical officers of the regular Navy. Applications may be made by dispatch and confirmed by following letter if the time element requires. (Professional Div., BuMed)

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From the Note Book

1. A section of "Space Medicine" is being established by the Aero Medical Association. Space Medicine is concerned with the medical problems involved in modes of travel, potentially capable at least of transporting us beyond the earth's gravitational field. It is also concerned with special hazards encountered in the upper part of our atmosphere and beyond. (Editorial, J. Aviation Med., October '50)

2. A symposium on "The Psychological Factors in Spatial Orientation" was held at the U. S. Naval Air Station, Pensacola, Florida, on 30 and 31 October 1950.

3. The U. S. Public Health Service has developed a handbook for photofluorographic operators. The publication should serve as a useful reference guide for all users and operators of photofluorographic equipment. It is available from Superintendent of Documents, GPO, Washington 25, D. C., at 45¢ per copy.

4. During the year of 1949 more than 14 million persons in the United States were screened for tuberculosis by chest photofluorography. (Pub. Health Rep., 3 November '50)

5. Among 1,550 American Indians ranging in age from under 1 to 20 years who were vaccinated in the period 1936-38 with BCG vaccine, 55 have died; 6 of these deaths were due to tuberculosis. Among 1,457 American Indians of comparable age who were not vaccinated, 108 have died; 52 of these deaths were from tuberculosis. In 123 children vaccinated several days after birth, 7 have died, but none from tuberculosis. Of 139 unvaccinated, 15 have died, 4 of which were due to tuberculosis. (32d report of the Henry Phipps Institute, J. D. Aronson)

6. Tiny objective lenses used in certain microscopes are smaller than a housefly's eye, but are accurate to 1 millionth of an inch. (Science News Letter, November '50)

7. Twenty-eight cases of cancer of the thyroid in children from 4 to 18 years of age are reported in the October 1950 Journal of Clinical Endocrinology. (B. J. Duffy and P. J. Fitzgerald)

8. "The Functional and Structural Changes Consequent to High Dosages of Radioactive Iodine" appears in the October 1950 Journal of Clinical Endocrinology, A. Garbman.

9. The chances that twins will be born are 1 in 92. Triplets are born once in 9,400 confinements and quadruplets once in 620,000 confinements. The likelihood

of quintuplets is extremely remote and the only 2 authenticated cases in medical history of "quints" surviving infancy are the Dionnes of Canada and the Diligentis of Argentina. The above figures are the results of a study involving 36,000,000 confinements from data from the National Office of Vital Statistics, Public Health Service. (Am. J. Surg., November '50)

10. An infrared heater in a 10-inch deep aluminum cup, controlled by an automatic thermostat which turns on the electric current and heat when the temperature approaches freezing, has been developed. The device has many uses from engine warming to frost protection. (Science News Letter, November '50)

11. A total of 210 hypertensive patients were studied and 52 patients selected for lumbar sympathectomy after specific medications and known contraindications for surgical intervention were applied. Substantial lowering of blood pressure was obtained in 33 (64 percent) with a lowering of pressure to below 150/100 in 19 (37 percent); symptomatic relief was achieved in 46 (88 percent). (Arch. Surg., November '50, J. E. Conley and F. Raime)

12. An editorial and a discussion of animal medical research appears in the November-December 1950 Bulletin of the National Society for Medical Research.

13. At a recent meeting, the regents of the American College of Surgeons voted unanimously to continue the program of hospital inspection. (Editorial, J.A.M.A., 11 November '50)

14. Immunization today is discussed in the November 1950 Medical Clinics of North America by CAPT Julien Love, MC, USN, and CDR J. F. Shane, MC, USN.

15. A technic of side-to-side porta caval anastomosis that gave good results in experimental surgery is described in the November 1950 Annals of Surgery by W. H. Ricker et al.

16. An interesting article by F. K. Meyer on "Reservoirs of Infection" appears in the October 1950 Journal of Pediatrics.

17. For the week ending 4 November 1950 a total of 1,089 new cases of acute poliomyelitis were reported. This was 17 percent less than the previous week when 1,315 cases were reported. The cumulative total (28,914) for the calendar year is well below that (39,028) reported for 1949. (National Office of Vital Statistics, Public Health Service)

18. The dangers of dicumarol therapy are discussed in the November 1950 Medical Clinics of North America by E. T. Phelps.



The Annual Syphilis Report, NavMed-A (Rev. 9-50) is now available at all district publication and printing offices. Request for copies of this form should be limited to not more than number required for making the annual and supplementary report for the years 1950 and 1951.

ANNUAL SYPHILIS REPORT

MAYNED-A (REV. 9-50)

(See instructions on reverse)

DATE \_\_\_\_\_

REPORT FOR YEAR OF

I ANNUAL SYPHILIS CENSUS (Total Number)

II NUMBER OF THESE INDIVIDUALS DIAGNOSED,  
TREATED, AND/OR FOLLOWED-UP DURING YEAR

III ANNUAL REPORT OF INDIVIDUALS DIAGNOSED, TREATED AND/OR FOLLOWED-UP DURING YEAR

LAST EXAMINATION  
(Date and Results)

[illegible]

# STS - Serological Test for Syphilis

SUBMITTED BY (Signature)

(MC) USN

## (REVERSE SIDE)

## INSTRUCTIONS

Annual Report - Prepare in DUPLICATE; submit original to BuMed as of 31 December.

ITEM I - Enter the number of individuals on board on 31 December who have a record of syphilis. (This is obtained by counting the number of Health Records on board which have a NavMed H-6 or H-7 with a diagnosis of syphilis recorded.)

ITEM II - Enter the total number of these individuals who were:

- a. Originally diagnosed and part or all of first year follow-up given within calendar year.
- b. Relapse, reinfection, neuro-recurrence or other complications within calendar year.
- c. Treatment begun or completed in previous year but part of first year follow-up falls within calendar year being reported on.

ITEM III - Enter complete data on all past and present Health Record entries of syphilis on each individual reported under ITEM II.

Supplementary Report - In order to obtain these data for personnel who are in a transient status on 31 December, the Health Records of all men reporting on board between 31 December and 1 March should be reviewed. Those with a syphilitic history and found to have been in a transient status on 31 December last, should be reported as noted above (ITEM I, II and III) on a supplementary NavMed-A not later than 15 March. Negative reports are not required.

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Establishment of Class "A" Hospital Corps School, Portsmouth, Virginia:

The Surgeon General, Rear Admiral Clifford A. Swanson, MC, USN, has announced that a basic course of instruction for Hospital Corpsmen has been established at the Hospital Corps School, Naval Hospital, Portsmouth, Virginia, effective January 1, 1951.

The new course for the school will be of 8-weeks duration. The subjects included in the curriculum are anatomy and physiology, first aid and minor surgery, nursing and dietetics, hygiene and sanitation, and materia medica.

Candidates successfully completing the prescribed course of instruction will be issued Certificates of Graduation and will be certified as Hospital Corpsmen. All graduates of Hospital Corps Schools are distributed through the Naval hospital system for duty and continued instruction. There are three Hospital Corps Schools presently operating at Great Lakes, San Diego, and Portsmouth. (PIO, BuMed)

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Enlistment Rejections - 1949: During 1949 a total of 160,259 male applicants for enlistment and reenlistment in the Navy and Marine Corps were



physically examined and 22,580, or 14 percent, were rejected because of physical or mental defects. Rejection rates for Marine Corps applicants were more than 50 percent higher than those for the Navy. As would be expected, rejection rates for reenlistments were much lower than those for first enlistment.

Of the 22,580 male applicants rejected during 1949, almost 90 percent were applicants examined for original enlistment in the service. The two leading causes, diseases of the eye and adnexa, and dental diseases and conditions, combined accounted for more than 40 percent of all rejections. In fact, 1 out of every 4 rejections was due to some deficiency of the eyes, principally errors of refraction. Among the dental disqualifications the outstanding conditions were defective teeth and abnormalities of teeth. Among Navy rejections, 10 percent were due to dental deficiencies as compared to 29 percent for Marine Corps rejections.

Nearly 1 out of every 10 rejectees was disqualified for service due to diseases of the motor system, the most frequent defects found being flatfoot and curvature of the spine.

The group "miscellaneous diseases and conditions" which in general covers deviations from the normal not included in other groupings, accounted for 1 out of every 7 rejections. The most frequent conditions in this group were overweight, underweight, deformities, and defective physical development. Navy rejectees for these causes accounted for 16 percent of their total as compared to a little over 10 percent among Marine Corps rejectees. (Stat. Navy Med., November '50)

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Ophthalmoscope Exhibit at the Armed Forces Institute of Pathology Medical Museum: An exhibit honoring Hermann von Helmholtz, the inventor of the ophthalmoscope, will be displayed under the auspices of the Medical Museum of the Armed Forces Institute of Pathology and the Army Medical Library in the Armed Forces Medical Museum at 9th and Independence Avenue, S. W., Washington, D. C., for six months beginning December 17, 1950. This date marks the 100th anniversary of Helmholtz' letter to his father describing the instrument which was to enable doctors to see the interior of the human eye for the first time.

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Repeat and Repeat: There are some safety rules that cannot be repeated too often. They are the simple rules--the grass-roots rules--the safe working fundamentals. They are so simple they are easily forgotten. So let's repeat:

1. **DON'T TAKE UNNECESSARY CHANCES.** Don't run up or down stairs--walk and use hand rail. Don't hitchhike on hand or power trucks. Stay off conveyors. Stay clear of suspended loads. Don't leave off goggles "just for a minute."

2. BE SURE YOU KNOW HOW. Never operate a machine without knowing exactly what you are doing. Do your lifting the right way.
3. NO HORSEPLAY--NO TRICKS. Kid stuff has no place in a shop or on a highway job. Tricks are stupid and dangerous.
4. NEVER USE EQUIPMENT WITHOUT AUTHORIZATION. Safe use of equipment takes more than curiosity--it takes training and experience.
5. HANDLE MATERIAL SAFELY. Lift with the legs, not with the back. Get help when you need it.
6. GET FIRST AID. Just a little puncture! Get first aid anyhow. For blisters, too. And for "something in the eye."
7. USE SAFE EQUIPMENT AND USE IT SAFELY. Ladder too short--no ladder at all--one may be as bad as the other. Never use air hose for dusting clothes or hair. Adjust wrenches so they don't slip. Replace guards before you use any machine.
8. WEAR SAFE CLOTHING. Floppy sleeves or ties will catch in machinery. Safety shoes are a good investment. For some jobs face shields or cup goggles are the answer. Gloves, apron, boots are needed when you handle chemicals.
9. KEEP A CLEAN WORK PLACE. Keep waste and scrap cleaned out. Stack materials out of the way--stack 'em so they won't fall.
10. FOLLOW SAFETY REGULATIONS. Respect signs--they're for your protection. Smoke only where it's safe to smoke. (Safety Review, October '50)

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List of Recent Reports Issued by Naval Medical Research Activities:

Naval Medical Research Unit No. 4, AdCom, USNTC, Great Lakes, Illinois,

The Prophylaxis and Treatment of Acute Respiratory Diseases with Antihistaminic Drugs, NM 005 051.11.01, 10 June 1950.

Naval Medical Field Research Laboratory, Camp Lejeune, North Carolina,

Intestinal Parasitic Infection in Military Personnel of the U. S. Marine Corps, NM 005 052.03, November 1950.

Note: Those interested in seeing copies of the complete reports should address their request to the research activity from which the report originated.

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BUMED CIRCULAR LETTER 50-123

9 November 1950

From: Chief, Bureau of Medicine and Surgery  
To: All Ships and Stations

Subj: Professional Examinations for Promotion of Dental Officers

Ref: (a) Manual of the Medical Department, Section III of Part I, Chapter 3  
(b) BuPers C/L 209-49; NDB Jul-Dec 1949, 49-913, p. 251  
(c) BuPers C/L 31-50; NDB of 3-15-50, 50-168  
(d) BuPers C/L 148-50; NDB of 9-15-50, 50-728

Encl: (A) Examination Plan for Dental Officers

1. In order to facilitate candidates' preparation for examinations for promotion, a definitive description of professional examinations, noted in broad terms in reference (a), is given in this letter. Except as otherwise set forth below, the provisions noted in references (b), (c), and (d) as generally applicable to professional examinations will apply to those for dental officers. Examinations will also conform to applicable parts of Naval Courts and Boards and Bureau of Naval Personnel Manual.

2. Examination areas, subjects, applicable promotion stages, and reference material are indicated in enclosure (A).

3. Examinations will have the following general characteristics:

a. Completion to be accomplishable within a three-day period.

b. Questions to be arranged by subject; subjects by general areas.

c. Duration not to exceed six sessions of approximately two hours each. Time allowed for objective-type questions to be exact; for essay-type to be unlimited but examinations in each subject, or any single combination of subjects, to be designed for completion in about two hours.

d. Subjects and thoroughness of coverage to vary, depending upon ranks involved; technical subjects being stressed in examinations for promotion through grades to commander; executive and operational subjects to be emphasized for promotion to captain.

e. Greater knowledge to be required in higher grades in cases of subjects common to several grades.

f. Technical questions, to extent practicable, to be objective-type; i.e., to require categorical answers or selection of one from several choices; other questions to require essay-type answers.

g. Examinations to be prepared by the Naval Examining Board for Dental Corps Officers (statutory examining board) and forwarded shortly after the date of announcement of selection to commanding officers of examinees for delivery to supervisory boards. Letter of transmittal to set the date of the examination; date and examination to be identical for all examinees of a given rank.

h. Where operational conditions prevent adherence to that date, the commanding officer of examinees to arrange a later date of examination, using the same questions, provided no advantage over other examinees ensues. Where there is a possibility of such advantage, commanding officer to request a substitute set of examination papers from the Naval Examining Board for Dental Corps Officers. In either event, account of the circumstances to be sent by the commanding officer to the Board.

i. Completed examinations to be transmitted as confidential matter by the supervisory board, via the commanding officer to:

Naval Examining Board for Dental Corps Officers  
Naval Dental School  
National Naval Medical Center  
Bethesda, Maryland

j. Questions not to be limited to matters specifically covered in references shown in enclosure (A), but to relate also to knowledge gained from well-rounded Naval experience.

4. Examinees will be exempted from examination in certain subjects upon submission of certified copies of certificates of completion of courses, evidence of award of a master of science degree, or designation as a diplomate of a specialty board, to the supervisory board for inclusion in the proceedings as follows:

a. Executive Area

(1) Administration

(a) Navy Regulations and General Orders.- Naval Correspondence course on subject administered by Naval Correspondence Course Center, New York, New York.

(2) Military Justice.- Military Law Correspondence Course administered by Naval Correspondence Course Center, New York, New York.



b. Technical Area.- Diplomate of American Boards of: Oral Surgery, Periodontology, Prosthodontics, or Oral Pathology in case of a directly related subject; master of science (field specified) in case of any one examination subject (or any single combination of subjects) in the field covered in attaining the degree.

c. Operational Area

(1) Logistics.- Naval War College (Logistics Course), Armed Forces Staff College, Industrial College of the Armed Forces, Logistics Correspondence Course administered by the Naval War College.

Exemptions in the cases of diplomates of specialty boards or examinees having master of science degrees in the examination subjects involved, are unrestricted; others are for one promotion only after completion of the course.

5. Officers attending a formal course of three or more months duration or having completed such a course within one month of announcement of selection, may, at own request, have their examinations postponed for one or two six-month periods. Requests for postponement should be sent to the Naval Examining Board for Dental Corps Officers as soon after announcement of selection as possible.

-H.L. Pugh, Acting

ENCLOSURE (A)

EXAMINATION PLAN FOR DENTAL OFFICERS

<u>Subjects</u>	<u>Promotion Stages 1/</u>	<u>References</u>
I. <u>Executive Area</u> 2/	2, 3, 4, 5	2/
II. Technical Area	2, 3, 4	3/
A. Oral Diagnosis and Roentgenology		(a) ORAL AND DENTAL DIAGNOSIS.- Thoma. (b) ORAL DIAGNOSIS AND TREAT- MENT.- Miller. (c) DIFFERENTIAL DIAGNOSIS OF ORAL LESIONS.-Bernler. (d) CLINICAL DENTAL ROENTGEN- OLOGY.-McCall and Wold. (e) ADVANCED RADIODONTIC IN- TERPRETATION.-Simpson. (f) DENTAL ROENTGENOLOGY.- Ennis.

<u>Subjects</u>	<u>Promotion Stages 1/</u>	<u>References</u>
B. Operative Dentistry		(a) AMERICAN TEXTBOOK OF OPERATIVE DENTISTRY.- Gabel. (b) OPERATIVE DENTISTRY.- Black. (c) ENDODONTIA.-Gottlieb.
C. Periodontia		(a) TEXTBOOK OF PERIODONTIA.- Miller. (b) PERIODONTIA.-Goldman.
D. Prosthodontia		(a) COMPLETE DENTURES.- Swenson. (b) PRINCIPLES AND TECHNIC FOR FULL DENTURE CON- STRUCTION.-Sears. (c) COMPLETE DENTURE PROS- THESIS.-Schlosser. (d) THEORY AND PRACTICE OF CROWN AND BRIDGE PROS- THESIS.-Tylman.
E. Oral Surgery		(a) ORAL SURGERY.-Mead. (b) SURGICAL TREATMENT OF FACIAL INJURIES.-Kazanjian and Converse. (c) TRAUMATIC SURGERY OF THE JAWS.-Thoma.
F. Oral Surgical Anatomy		(a) ORAL ANATOMY.-Fischer. (b) APPLIED ANATOMY OF HEAD AND NECK.-Shapiro.
G. Applied Pathology and Bacteriology		(a) HISTOPATHOLOGY OF THE TEETH AND THEIR SUR- ROUNDING STRUCTURES.- Kronfeld. (b) ORAL PATHOLOGY.-Thoma. (c) CLINICAL PATHOLOGY (etc.).- Coolidge. (d) DISINFECTION AND STERILI- ZATION.-McCulloch.



Subjects

Promotion Stages 1/

References

H. Dental Materia Medica  
and Therapeutics

- (e) BACTERIAL CHEMISTRY AND  
PHYSIOLOGY.-Porter.
- (f) BACTERIAL INFECTION.-Appleton.

- (a) PRESCRIPTION WRITING AND  
MATERIA MEDICA FOR  
DENTISTS.-Cipes
- (b) PHARMACOLOGY AND DENTAL  
THERAPEUTICS.-Prinz,  
Rickert, Dobbs.

III. Operational Area

4/

A. Organization, Management and Operation - BuMed,  
Naval Dental Clinic, and  
dental department 4,5

- (a) U.S. NAVY REGS AND GENERAL  
ORDERS
- (b) NAVY DEPARTMENT BULLETIN
- (c) MANUAL OF THE MEDICAL DE-  
PARTMENT
- (d) U.S. NAVY FILING MANUAL  
(NavExos P-20)
- (e) NAVY CORRESPONDENCE  
MANUAL (NavExos P-388)
- (f) STANDARD SHIP ORGANIZATION
- (g) NAVY ALLOTMENT PROCED-  
URES (NavExos P-487)
- (h) BUPERS AND BUSANDA  
MANUALS
- (i) BULLETIN BUMED CIRC. LTRS  
(NavMed 937)

B. Training - dental personnel 4,5

- (a) LIST OF NAVY SCHOOLS AND  
COURSES (NavPers 15795)
- (b) HANDBOOK FOR DENTAL  
TECHNICIANS (GENERAL)
- (c) CATALOG OF TRAINING FILMS  
FOR THE U.S. NAVY AND  
MARINE CORPS.-(NavAer 00-  
80-V-69)
- (d) HANDBOOK FOR DENTAL  
TECHNICIANS (PROSTHETIC)
- (e) QUALIFICATION MANUAL FOR  
ADVANCEMENT IN RATING  
(NavPers 18068)

SubjectsPromotion Stages 1/References

		(f) EDUCATION AND TRAINING (NavPers 10827)
		(g) MANUAL FOR NAVY INSTRUCTORS (NavPers 16103-B)
C. Dental Records - treatment, personnel, materiel, and financial	3, 4, 5	(a) MANUAL OF THE MEDICAL DEPARTMENT (b) BUPERS AND BUSANDA MANUALS
D. Dental Logistics - fleet, advanced base, and shore facilities and materiel; requirements, procurement and distribution <u>5/</u>	5	(a) ARMED SERVICES CATALOG OF MEDICAL MATERIEL (b) LOGISTICS GLOSSARY (NavPers 91084) (c) LOGISTICS REFERENCE DATA (NavPers 91085) (d) ADVANCED BASE INITIAL OUTFITTING LIST (NavSanda 28) (e) CATALOG OF ADVANCED BASE FUNCTIONAL COMPONENTS (OpNav-P415-100) (f) ADVANCED BASE MANUAL (OpNav 415-P-107)
E. Responsibilities - fleet, district and staff dental officers	5	(a) MANUAL OF THE MEDICAL DEPARTMENT (b) U. S. NAVY REGS AND GENERAL ORDERS

1/ Promotion stages are: 2, to lieutenant; 3, to lieutenant commander; 4, to commander; 5, to captain.

2/ Same as Category One, Part I of Enclosure (a) to BuPers C/L 148-50 (NDB of 15 Sep 1950, 50-728) except Military Justice questions to be omitted until 1 May 1951. There will be no examination in International Relations.

3/ References applicable to the Technical Area are for guidance purposes only; any standard texts may be used. In addition to textbooks shown, reference may be made to professional periodicals; such as the journals of American Dental Association, Oral Surgery, Dental Research, Dental Education, Periodontology, etc.

4/ Operational Area references are for general guidance; familiarity with each being helpful but not essential since there is overlapping and subject matter is also covered by other publications, directives, and correspondence.



5/ Until 1 May 1951, logistics questions will be restricted to those answerable on the basis of widely disseminated directives and normal Naval experience.

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JOINT LETTER

BUPERS-G14-svd  
P1-5(A)  
14 November 1950

BUMED-2112-LGA  
P3-2/NH  
14 November 1950  
BuMed C/L No. 50-124

MARCORPS  
14 November 1950

From: Chief of Naval Personnel  
Chief, Bureau of Medicine and Surgery  
Commandant of the Marine Corps

To: All Ships and Stations

Subj: New Identification Card for Hospitalization and Medical Care of Dependents of Naval and Marine Corps Personnel; Instructions Regarding

1. Dependent's Identification Card for Medical Care has been revised and given Form No. NavPers-1343 (New 8-50) replacing NavMed-562 (2-45). These forms may be obtained from district publications and printing offices in the usual manner.
2. Commanding Officers will make necessary arrangements for the issuance of the new card (NavPers-1343 (New 8-50)) upon the request of members of their commands having dependents. It is suggested that, in each command, the importance of obtaining a card before an emergency arises be emphasized so that there will be no delay incident to obtaining a card when a dependent requires medical attention. In regard to NavMed-562 (2-45) currently valid, such card will continue to be honored until the date of expiration indicated on the card. In order for entitlement to dependent medical care to continue after such expiration date, it will be necessary for the service member to apply for a new Dependent's Identification Card for Medical Care (NavPers-1343 (New 8-50)). Whenever it is not possible for the service member to procure and deliver this card to the dependent concerned, due to exigencies of the service, the dependent, or a person on behalf of the dependent, may procure a card from either the Bureau of Naval Personnel or Marine Corps Headquarters as appropriate. Meanwhile, no dependent in possession of an otherwise valid NavMed-562 (2-45) will be denied medical or hospital care pending receipt of the revised card.
3. Cards must be attested by an officer in each command authorized by the commanding officer to issue such cards.

4. Cards covering group dependents should normally be endorsed by the senior dependent.
5. Separate cards must be issued for each dependent or group of dependents residing at different addresses.
6. As dependents are acquired or changed the Dependent's Identification Card should be corrected or reissued as appropriate.
7. The card will be void after date appearing on face thereof, but may be reapplied for and reissued if requirements listed on reverse side of the card are met.
8. Cognizant district commandants are authorized to issue cards to Naval personnel retired with pay, including members of the Fleet Reserve entitled to retainer pay, or their dependents. Marine Corps Headquarters will issue the card to their personnel retired with pay or Fleet Marine Reserve entitled to retainer pay, or their dependents.
9. Unremarried widows of members of the regular service, or of regular or reserve personnel who were entitled to retirement or retainer pay at time of death, or of reserve members who died on active duty, may procure the card from the Bureau of Naval Personnel or Marine Corps Headquarters as appropriate.
10. This card is void at time of separation from military service, or on release to inactive duty, or remarriage of widows otherwise entitled, and when practicable must be delivered to the personnel officer having the individual's records.
11. Dependents may apply for care at Army or Air Force facilities, if Navy facilities are not available. In making application for care at such activities this card may be presented. However, if additional proof of relationship and dependency is requested it should be furnished without question.

BUPERS--J. W. ROPER

BUMED--C. A. SWANSON

MARCORPS--C.B.Cates

\* \* \* \* \*

JOINT LETTER

10 November 1950

BUMED CIRCULAR LETTER 50-125; C 1 SR 40-410-10; AFR 160-55A

Subj: Central Facilities Provided for Department of Defense by Armed Forces Institute of Pathology

Ref: (a) Army-Navy-Air Force joint letter of 8 June 1950; BuMed Cir Ltr 50-50, SR 40-410-10, AFR 160-55



1. Paragraph 8a of reference (a) is changed as follows:

	Army areas and Air Force installations therein	Name and location of center	Naval District
In place of present first listing, substitute:		U.S. Naval Hospital, St. Albans, Long Island, N.Y.	First Naval District Third Naval District
	First Army Area and First Air Force and adjacent island bases	First Army Area Medical Laboratory, 90 Church Street, New York, N. Y.	
In place of present fifth listing, substitute:	Third Army Area and Fourteenth Air Force	Third Army Area Medical Laboratory, Fort McPherson, Ga.	

By order of the Secretaries of the Army, the Navy, and the Air Force:

OFFICIAL:  
EDWARD F. WITSELL  
Major General, USA  
The Adjutant General

J. LAWTON COLLINS  
Chief of Staff, United States Army

OFFICIAL:  
CHARLES WELLBORN, JR.  
Deputy Chief of Naval Operations  
(Administration)

C. A. SWANSON  
Chief of the Bureau of Medicine  
and Surgery  
Department of the Navy

OFFICIAL:  
L. L. JUDGE  
Colonel, USAF  
Air Adjutant General

HOYT S. VANDENBERG  
Chief of Staff, United States Air  
Force

Note: The above letter will not be printed in the Navy Department Bulletin.

\* \* \* \* \*

BUMED CIRCULAR LETTER 50-126

14 November 1950

From: Chief, Bureau of Medicine and Surgery  
To: All Ships and Stations

Subj: Naval Hospitals Designated to Receive Patients Who Require Specialized Treatment

Ref: (a) Article 11-36(2), ManMedDept  
 (b) BuMed Cir Ltr 49-32;NDB Jan-Jun 1949, 49-166, p. 77  
 (c) BuMed Cir Ltr 49-44  
 (d) BuMed Cir Ltr 49-97

1. References (b) through (d) are hereby cancelled.

2. Patients who require definitive treatment and specialized medical care will be transferred from naval hospitals not having adequate facilities to one of the naval hospitals listed below, as appropriate:

<u>Item</u>	<u>Type Treatment or Care</u>	<u>Naval Hospital</u>
a.	Amputations - - - - -	Oakland, Calif. Philadelphia, Pa.
b.	Blindness and Aural Rehabilitation - - -	Philadelphia, Pa.
c.	Acrylic Ocular Prosthesis - - - - -	Bethesda, Md. San Diego, Calif.
d.	Neurology - - - - -	Bethesda, Md. Oakland, Calif. Philadelphia, Pa.
e.	Neuropsychiatry - - - - -	Oakland, Calif. Philadelphia, Pa.
f.	Neurosurgery - - - - -	Bethesda, Md. Chelsea, Mass. Oakland, Calif. St. Albans, N. Y.
g.	Oncology - - - - -	Oakland, Calif. St. Albans, N. Y.
h.	Plastic Surgery - - - - -	Bethesda, Md. Oakland, Calif. San Diego, Calif.
i.	Thoracic and Cardiovascular Surgery -	San Diego, Calif. St. Albans, N. Y.



j. Tuberculosis - - - - - St. Albans, N. Y.  
San Diego, Calif.

3. Requests for specific authority for transfer in each case shall be submitted to the Bureau of Medicine and Surgery or the naval district commandant as outlined in reference (a).

-H. L. Pugh, Acting

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SECNAV LETTER, Op213C/gs, Serial 3845P21

16 October 1950

To: All Ships and Stations

Subj: Change in Command Relationship of U. S. Naval Hospital, Guam,  
Marianas Islands

Ref: (a) SecNav ltr. Op213C/cjh, serial 1940P21 of 7 Aug 1950; N. D. Bul.  
of 15 Aug 1950, 50-593

1. The following activity is hereby placed under the military command of Commander Naval Forces, Marianas:

U. S. Naval Hospital  
Guam, Marianas Islands  
(Mail Address)  
Commanding Officer  
U. S. Naval Hospital  
Navy No. 926  
Fleet Post Office  
San Francisco, Calif.

3435-348

This activity remains under the management control of the Bureau of Medicine and Surgery.

2. Paragraph 3 of reference (a) is modified accordingly.

3. Bureaus and offices concerned take necessary action.

-SecNav Francis P. Matthews

\* \* \* \* \*

ALNAV 127

15 November 1950

Subj: Written Professional Examinations; Cancellation of

AlNav 127. Until further notice all written professional examinations for promotion of officers are cancelled. Officers concerned, in absence of objection by them, will be examined on record. In cases where a naval examining board finds an officer's record inconclusive the board may take such action with regard to further examination as circumstances in individual case may warrant including but not restricted to arranging for personal appearance of officer before the board. Officers now scheduled for reexamination or delayed examination must complete them as previously scheduled.

-Dan A. Kimball

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NAVY DEPARTMENT  
BUREAU OF MEDICINE AND SURGERY  
WASHINGTON 25, D. C.

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PAYMENT OF POSTAGE. \$300

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